United Healthcare Community Plan

COMMONWEALTH OF VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Service Authorization (SA) Form

Continuous Glucose Monitors

If the following information is not complete, correct, or legible, the SA process can be delayed.

Please use one form per member.

MEMBER INFORMATION

Last Name: _____

First Name: _____

Medicaid ID Number: _____

Date of Birth: _____

PRESCRIBER INFORMATION

Last Name: _____

First Name: _____

NPI Number: _____

Phone Number: _____

Fax Number: _____

CONTINUOUS GLUCOSE MONITOR (CGM) INFORMATION

CGM Product (Please include all pieces needed for use): _____

_____

Frequency of sensor use: _____

Length of Therapy: _____

(Form continued on next page.)

Member's Last Name: **Member's First Name:**

DIAGNOSIS AND MEDICAL INFORMATION

For an initial request, complete the following questions to receive a 12-month approval:

1. Is the member at least 2 years of age? **AND**

   ☐ Yes ☐ No

2. Has the member been diagnosed with diabetes by their primary care physician, or another licensed health care practitioner authorized to make such a diagnosis? **AND**

   ☐ Yes ☐ No

3. Is the member being treated with insulin and/or does the member have a history of problematic hypoglycemia? **AND**

   ☐ Yes ☐ No

4. Has the member's treating practitioner concluded that the member (or member's caregiver) has had sufficient training using the continuous glucose monitor prescribed as evidenced by providing a prescription? **AND**

   ☐ Yes ☐ No

5. Has the continuous glucose monitor been prescribed in accordance with the Food and Drug Administration indications for use?

   ☐ Yes ☐ No

(Form continued on next page.)

Member's Last Name: **Member's First Name:**

For a renewal request, complete the following questions to receive a 12-month approval:

1. Does the member continue to meet the relevant criteria identified in the initial criteria? **AND**

   ☐ Yes ☐ No

2. Is the member being monitored for benefit of using the continuous glucose monitor by way of follow up every 6 months in the first 18 months of use or annually after the first 18 months of use?

   ☐ Yes ☐ No

Prescriber Signature (Required) **Date**

By signature, the physician confirms the above information is accurate and verifiable by member records.

Please include ALL requested information; incomplete forms will delay the SA process.
Submission of documentation does NOT guarantee coverage by the Department of Medical Assistance Services.

Fax this form to 1-866-940-7328

Pharmacy PA Call Center 1-800-310-6826